# RHS SCHOOL-BASED HEALTH SERVICES
## CHILD ENROLLMENT FORM
### Questions? 803-219-1926

**Rural Health Services, Inc. (RHS)** has partnered with your child's school to provide healthcare and dental services during school hours through our school-based health team. Services are provided to all students regardless of their ability to pay or if they are insured. **Parents will never receive a bill but private insurance or Medicaid will be billed.**

**The information must be filled out in ink by a parent or legal guardian. If your child already has a dentist or doctor, you should keep going to that dentist or doctor.**

**MEDICAL SERVICES INCLUDE:**
Well-child exams, medical screening (blood), & head-to-toe examination, treatment, and nutritional counseling.

**DENTAL SERVICES INCLUDE:**
Exam, x-rays, cleanings, sealants, and Fluoride. Additional parental consent is required for operative work (fillings).

**BEHAVIORAL HEALTH SERVICES INCLUDE:**
Screening to identify behaviors that hinder success in school, home, or community. Counseling and/or intervention as needed will be provided with parental consent.

**I WANT MY CHILD TO BE SEEN BY (CHECK SERVICES THAT APPLY):** ☐ Medical Staff Only ☐ Dental Staff Only ☐ Both Medical & Dental ☐ Behavioral Health (Ridge Spring Elem. & CIL only)

## CHILD'S PERSONAL INFORMATION

**School:** _____ **Grade:** _____ **Teacher:** _____

**First Name:** _____ **Last Name:** _____ **Parent/Guardian Email:** _____

**Date of Birth :** ☐☐ / ☐☐ / ☐☐ (M M / D D / Y Y) **Age:** _____ **Social Security :** ☐☐☐ - ☐☐ - ☐☐☐☐

**Address :** _____ **City:** _____ **State:** _____ **Zip:** _____

**Emergency Contact:** _____ **Phone:** ☐☐☐ - ☐☐☐ - ☐☐☐☐ **Relationship:** _____

**Primary Doctor:** _____ **Dentist:** _____

## HELP US GET TO KNOW YOUR CHILD BETTER

**Gender at birth :** ☐ Male ☐ Female **Gender Identification :** _____

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race (Check All That Apply) :** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Prefer not to say ☐ Multi-races _____

**Preferred Language:** ☐ English ☐ Spanish ☐ Other _____ **Translator needed?** ☐ Yes ☐ No

**Housing:** ☐ Single Family Home ☐ Homeless ☐ Doubling up ☐ Shelter ☐ Transitional Housing ☐ Other/Prefer not to say

## INSURANCE INFORMATION (REQUIRED)

As the **Responsible Party**, **I understand that my dental or medical insurance carrier or payer of my benefits will be billed for services rendered. Medicaid or private insurance is accepted as payment in full for service(s).** If your child's insurance changes during the year make sure that we get an updated copy of your insurance card and/or updated insurance information.

☐ **CHILD HAS MEDICAID**

**Medicaid Provider** _____ **Medicaid #:** _____

☐ **CHILD HAS PRIVATE INSURANCE:**

**Insurance Company Name:** _____ **Phone # of Company:** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Policy Holder's Name:** _____ **Employer:** _____

**Policy Holder's ID or SS#** _____ **Group#:** _____

**Date of Birth :** ☐☐ / ☐☐ / ☐☐ (M M / D D / Y Y) **Phone # of Policy Holder** ☐☐☐ - ☐☐☐ - ☐☐☐☐

☐ **CHILD HAS SEPARATE DENTAL INSURANCE:**

**Insurance Company Name:** _____ **Phone # of Company:** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Policy Holder's Name:** _____ **Employer:** _____

**Policy Holder's ID or SS#** _____ **Group#:** _____

**Date of Birth :** ☐☐ / ☐☐ / ☐☐ (M M / D D / Y Y) **Phone # of Policy Holder** ☐☐☐ - ☐☐☐ - ☐☐☐☐

☐ **CHILD IS UNINSURED (NO INSURANCE):**
**CALL 803-679-4243 to speak to our state-wide marketplace navigator or certified insurance application counselors.**

## FAMILY INFORMATION

Parent/ Guardian:

Address : City: State: Zip:

Home Phone: - - Cell Phone: - - Email:

Preferred Pharmacy: Family Yearly Income Level: $

Address/Phone # of Pharmacy - -

Date of the last time your child saw a dentist of doctor?

Date of Dentist : M M / D D / Y Y Date of Doctor: M M / D D / Y Y

Would you like any other adult to be able to give permission to treat your child? This would also allow the dental and medical team to talk about your child's health, treatment, and recommendations with this adult. If yes, please provide:

Full Name: Phone #: - - Relationship to child:

## MEDICAL HISTORY

**Write Yes (Y) or No (N) on the line provided beside the question.**

Has the student had surgery in the past? If yes, EXPLAIN why: _____

Are any of the child's teeth causing pain? _____

Does the child smoke, use tobacco and/or recreational drugs? _____

Is the student pregnant or possibly pregnant? _____

Have there been any changes in the student's health in the past year? EXPLAIN: _____

Has the student ever been hospitalized overnight? If so, list dates and the reason: _____

Has the student had any serious or sport-related injuries? _____

Does the student have any allergies (food, medication, anesthetics, latex, etc.)? If so, list them: _____

Has your child been in contact with the AIDS virus or have they tested positive for HIV? _____

Does your child take any daily medications, including over-the-counter or inhalers? If yes, explain: _____

### Check all that apply for your child:

- ☐ High or low blood pressure
- ☐ Ulcer or Acid Reflux
- ☐ Heart Transplant
- ☐ Pacemaker
- ☐ Recent Blood Transfusion
- ☐ Sinus Problems (Hay Fever)
- ☐ Stroke or mini-stroke
- ☐ Congenital Heart Disease
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Epilepsy and/or Seizure
- ☐ Cancer/Radiation/Chemo
- ☐ Bacterial Endocarditis
- ☐ Cortisone Steroid Treatment
- ☐ Heart conditions including murmur
- ☐ Nervous Disorder/Behavioral Problems
- ☐ Learning Disability or Special Needs
- ☐ Anemia (incl. sickle cell anemia) Type: _____
- ☐ Artificial or prosthetic heart valve, stent, or graph
- ☐ Sexually Transmitted Infection (Disease). EXPLAIN: _____
- ☐ Asthma, Breathing Problems or lung disorder, EXPLAIN: _____
- ☐ Kidney Trouble, EXPLAIN: _____
- ☐ Tuberculosis, MRSA, or any other infectious disease. EXPLAIN: _____
- ☐ Asthma, Breathing Problems or lung disorder, EXPLAIN: _____
- ☐ Liver disease, Hepatitis, jaundice, bleeding disorder or history of Leukemia. EXPLAIN: _____
- ☐ Does your child have any other medical problems not listed? If yes, please list and explain: _____

## AUTHORIZATION

1. I authorize the School-Based Dental Staff to perform diagnostic procedures and treatment as may be necessary for proper dental care, including (but not limited to) exams, x-rays, cleanings, and sealants.
2. I authorize the RHS School-Based Medical Staff to perform a well-child checkup including medical examination, screening, treatment and/or behavioral health screening.
3. I authorize the RHS School-Base Medical Staff to immunize my child and/or administer flu shot if needed.
4. I authorize the RHS School-Based Behavioral Health Staff to conduct screening to identify behaviors that hinder success in school, home, or community (Ridge Spring Elem. & CIL only).
5. I authorize the release of any information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
6. I authorize the release of any information regarding my child's healthcare, advice, and treatment to another dentist, doctor, or school nurse/official
7. I authorize payment of insurance benefits directly to Rural Health Services.
8. I attest to the accuracy of the information provided in this form. I understand that it is my responsibility to inform the RHS staff of any changes in my child's insurance and medical status on or before the next appointment.
9. I understand that services may be provided in person or virtually via telehealth.

**Acknowledgement of Receipt of Notice of Privacy Practices and Authorization of PHI Disclosure**
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights can be found at www.HHS.gov. By returning this form to my child's school, I acknowledge my understanding of my rights concerning HIPAA. I also am aware that treatment plans that may contain health information may be sent home with my child for my review. I understand that I may revoke this authorization at any time by contacting RHS at the contact information listed below.

Parent or Guardian Signature: _____ Date: M M / D D / Y Y